Minutes of the Special Meeting of the Board of Directors of the Cook County Health and Hospitals System (CCHHS) held Thursday, May 5, 2016 at the hour of 4:00 P.M. at 1900 West Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Hammock called the meeting to order.

Present: Chairman M. Hill Hammock and Directors Ada Mary Gugenheim; Emilie N. Junge; Wayne M. Lerner, DPH, LFACHE; Carmen Velasquez; and Dorene P. Wiese (6)

Absent: Vice Chairman Hon. Jerry Butler and Director Erica E. Marsh, MD, MSCI (2)

Present Telephonically: Directors Ric Estrada and Mary B. Richardson-Lowry (2)

Director Lerner, seconded by Director Gugenheim, moved to allow Directors Estrada and Richardson-Lowry to participate in the meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Additional attendees and/or presenters were:

Ekerete Akpan – Chief Financial Officer
Letitia Close – Executive Director of Government Affairs
Douglas Elwell – Deputy CEO of Finance and Strategy
John Kelly – Lobbyist, All-Circo Inc.
Jeff McCutchan – Interim General Counsel
Deborah Santana – Secretary to the Board
Richard H. Sewell - Associate Dean, Community and Public Health Practice at UIC School of Public Health
John Jay Shannon, MD – Chief Executive Officer
Jonathan Sheiner – Lobbyist, Susan J. White & Associates
Susan White – Lobbyist, Susan J. White & Associates

II. Public Speakers

Chairman Hammock asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Recommendations, Discussion / Information Item

A. Strategic planning discussion

Topic: State and Federal Landscape, presented by Susan White and Jonathan Sheiner of Susan J. White and Associates, and by John Kelly, of All-Circo, Inc. (Attachment #1)

Dr. Shannon provided an introduction to the presentation. He also introduced Richard Sewell, Associate Dean of Community and Public Health Practice at UIC School of Public Health, who will be moderating the strategic planning discussions.

III. Recommendations, Discussion / Information Item

A. Strategic planning discussion (continued)

The presentation included information on the following subjects:

State:

- State FY2016 Budget Backdrop
  -Budget
  -Status
- Illinois General Assembly
- Illinois House and Senate Committees
- Executive Order 16-05
- Key 2016 Dates

Federal:

- Patient Protection & Affordable Care Act (ACA)
- Medicaid
- Medicaid Disproportionate Share (DSH)
- Health Disparities Affecting Minority Populations – Urban American Indians
- Caps and Allotments: Medicaid DSH
- Medicaid DSH & ACA
- Medicaid Local Government Match & Intergovernmental Transfers
- Medicaid Expansion
- Future of Medicaid
- Medicaid Managed Care Rule
- Waivers
- Justice Involved Populations
- Mental Health, Substance Abuse & Opioid Addiction
- Section 340(b), Public Health Service Act
- Medicare and the Post Acute Care (PAC)
- Medicaid Graduate Medical Education (GME)
- Other Federal Funding for Health
- CCHHS Strategic Priorities

Mr. Kelly reviewed the information pertaining to the State landscape, and Ms. White and Mr. Sheiner reviewed the information regarding the federal landscape.

Following the Board's review and discussion of the State and Federal Landscape presentation, Mr. Sewell reviewed a presentation regarding the planning process and strategic priorities (Attachment #2). The Board discussed the information.

IX. Adjourn

As the agenda was exhausted, Chairman Hammock declared that the meeting was ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
M. Hill Hammock, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

Strategic Planning Discussion

State & Federal Landscape

May 5, 2016

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

State

State FY2016 Budget Backdrop

- New Leadership
- Temporary Income Tax Expiration
- FY2015 Budget Deficit
  - 2.25% Across the Board Cut
  - Special Fund Sweeps
  - $1.6B cut 4th Quarter FY2015 Budget

State FY2016 Budget

- FY 2016 $6.2B Revenue Shortfall
- Reduced Medicaid Spending
- Turnaround Agenda

State FY2016 Budget Status

- 11th Month of FY2016 Without a Budget
- Consent Decrees & Court Orders
- Spending at 2011 Income Tax Rate
- $7B+ Unpaid Bills

State FY2017 Budget

- Governor's FY2017 Operating Budget
  - Introduced in February 2016
    - $3.5B Operating Deficit
    - Deferred Pension Payments
    - Reduced Cost of Employee Health Insurance
    - Depletion of the Budget Stabilization Fund

- FY2017 begins July 1, 2016
  - $10M Estimated Bill Backlog

Illinois General Assembly

- Key Areas of Focus
  - Adequate Funding for Human and Social Services
  - Behavioral Health
  - Medicaid
  - Managed Care Oversight
  - Reduced Spending
  - Transparency

Committees

Senate Committees

Human Services	Chair – Senator Dan Biss
Local Government	Chair – Senator Emil Jones III
Public Health	Chair – Senator John Mulroe
Special Committee on Oversight of Medicaid Managed Care	Chair – Senator Heather Steans

House Committees

Appropriations – Human Services	Chair – Representative Greg Harris
Health & Healthcare Disparities	Chair – Representative Will Davis
Healthcare Availability & Accessibility	Chair – Representative Mary Flowers
Healthcare Licenses	Chair – Representative Mike Zalewski
Human Services	Chair – Representative Robyn Gabel
Special Committee on Substance Abuse	Chair – Representative Lou Lang

Executive Order 16-05

- **Health Care Fraud Elimination Task Force**
  - intent to root out waste, fraud and abuse in taxpayer-funded health programs
  - areas of focus to include Medicaid and the State Employee Group Health Insurance Programs

Key 2016 Dates

- January 27th — Governor's State of the State
- February 17th — Governor's Budget Address
- May 31st — Last day of "Regular" Session
- June 30th — Last day of State Fiscal Year
- November 8th — Presidential Election
- Fall 2016 — Veto Session

Federal

Patient Protection & Affordable Care Act (ACA)

- Established in 2010

- The ACA contains nine titles, each addressing an essential component of reform:
  - Quality, affordable health care for all Americans
  - Role of public programs
  - Improving the quality and efficiency of health care
  - Prevention of chronic disease and improving public health
  - Health care workforce
  - Transparency and program integrity
  - Improving access to innovative medical therapies
  - Community living assistance services and supports
  - Revenue provisions

http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf

Medicaid

- 42 U.S. Code, Chapter 7, Subchapter XIX
  - Section 1396a[1]
- Created in 1965
  - Public Law 89-97
- Illinois is a 50-50 state
  - Poorer states receive a higher percentage of their Medicaid paid by the federal government

1) https://www.law.cornell.edu/uscode/text/42/1396a

Medicaid Disproportionate Share (DSH)

- FY 2015 Illinois received $232,959,8014[1]
- Payments made to hospitals serving a large number of uninsured and Medicaid patients

- States must “take into account the situation of hospitals which serve a disproportionate number of low income patients” (OBRA) of 1981[2]

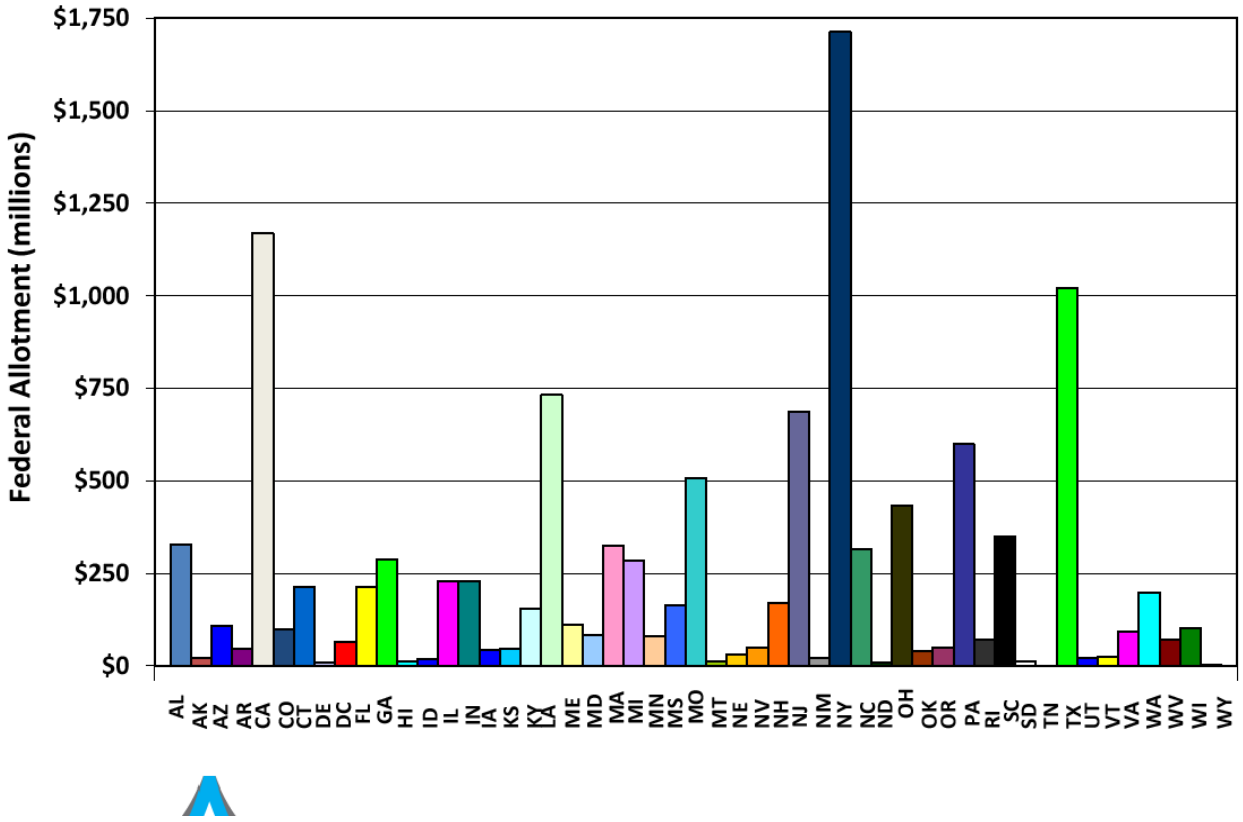
1) http://kff.org/medicaid/state-indicator/federal-dsh-allotments/
2) http://essentialhospitals.org/wp-content/uploads/2015/07/Mutinsky_MedcaidMedicareDSH_062415_vF.pdf

Health Disparities Affecting Minority Populations – Urban American Indians

- Medicaid Disproportionate Share (DSH) and supplemental payment programs designed to assist providers treating specific populations
- Innovative and collaborative approaches
- LA County Department of Health Services strategic priority

Caps and Allotments: Medicaid DSH Set in Balanced Budget Act of 1997 (P.L. 105-33)

STATE ALLOTMENTS OF FEDERAL DSH FUNDS



Low DSH States

- Alaska
- Arkansas
- Delaware
- Hawaii
- Idaho
- Iowa
- Minnesota
- Montana
- Nebraska
- New Mexico
- North Dakota
- Oklahoma
- Oregon
- South Dakota
- Utah
- Wisconsin

1) http://essentialhospitals.org/wp-content/uploads/2015/07/Mutinsky_MedcaidMedicareDSH_062415_vF.pdf

Medicaid DSH & ACA

- DSH was deemed redundant by the drafters of the ACA as it was meant to reduce uninsured and that is the target audience for DSH dollars
- Total cuts of $14.1 billion over 7 years
- DSH cuts originally scheduled to begin in FY 2014 but now pushed back to FY 2018
- Cuts will be up to 50% of DSH dollars

Medicaid Local Government Match & Intergovernmental Transfers (IGT's)

- Part of original Medicaid statute in 1965
- Section 1903(w)(6)(A) of the Social Security Act
  - "the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider."

Medicaid Expansion

31 states and Washington, DC have expanded Medicaid

source: http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx

Future of Medicaid

- Transfer from “fee for service” to Managed Care
- Block grants and per capita caps have been proposed.
- Since the creation of the Medicaid and Medicare programs in 1966, discussions continue on costs, structure and sharing of risk

Medicaid Managed Care Rule

- Background
  - Rule released on April 25, 2016
  - CMS statement on reaching major goals

- What we know Now
  - Phases out directed payments or “pass through” over 10 years
  - 10% cut each year
  - Shrinks rate ranges

- Takeaways
  - States must create their own network adequacy standards for private Medicaid plans
  - Managed care plans are subject to a medical loss ratio of at least 85%
  - Mentally ill could have expanded access by easing restrictions on re-imbursements
  - Quality rating system for Medicaid plans similar to Medicare advantage

source- Politico Pro "MAKING SENSE OF THE MEDICAID MEGA-REG" by Dan Diamond

Waivers

- 1115 Medicaid Demonstration Waiver

- California Waivers
  - New “Medi-Cal 2020” Waiver
  - Previous 1115 Waiver
  - Medicaid Expansion and Enrollment and Delivery System Reform Incentive Program (DSRIP) Waiver

Justice Involved Populations

- CMS allows for suspension, rather than termination of Medicaid benefits

- CMS Sub-Regulatory Guidance
  - Justice Involved Individuals

- National Association of Counties (NACo) Proposal

Mental Health, Substance Abuse & Opioid Addiction

- Congress is trying to improve the response of government to mental illness.
- Several bills are being considered with goals to streamline the federal response, make care more readily available, providing more grant money for varied programs, and improving workforce development.
- Congress and the Administration are responding to the growing opioid addiction epidemic.
- Legislation will add significant funding for grants to state and local governments and non-profits for education, treatment alternatives, and the facilitation of the destruction of unused opioids.
- Legislation also pending to provide relief from liability for providers who administer opioid relief drugs.

Section 340(b), Public Health Service Act

- Nonprofit and public hospitals with high shares of Medicaid and low-income Medicare patients (DSH) qualify for the **340B Drug Pricing Program.**

- The program requires drug companies to sell drugs dispensed by these hospitals outside of inpatient care and to other than patients with Medicaid at a discount. (Drugs dispensed to Medicaid beneficiaries are sold under discount authorized under a separate provision of federal law.)

Medicare and the Post Acute Care (PAC)

- Post Acute Care has become more important as the length of acute care inpatient stays have been reduced.

- PAC is delivered by Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and home care.
  - Each silo has a different reimbursement scheme.

- Policy makers have decided that the process needs to be simplified and more of the risk be allocated from the payers to the providers.
  - Episodic Bundled Payments
  - Site Neutral Payment

Medicaid
Graduate Medical Education (GME)

- Medicaid title of SSA does not require, but will match state Medicaid payments to providers for Graduate Medical Education (GME) costs
- 40 states provide GME payments
- States use varied methods to determine payments including capitations and supplemental payments
- Some states use GME payment as incentives for training for certain specialties

Other Federal Funding for Health

- Federally Qualified Health Centers (FQHC)
- National Institutes of Health
  - FY16- $32 billion
- Health Resources and Services Administration (HRSA)
  - FY16 $6.3 billion
  - Ryan White programs $2.3 billion

CCHHS Strategic Priorities

- Protection of Medicaid
- BIPA
- 340(b)
- Medicaid Managed Care
- Behavioral Health

ATTACHMENT #2

Planning Process and Strategic Priorities

COOK COUNTY HEALTH AND HOSPITALS SYSTEM BOARD MEETING

THURSDAY, MAY 5, 2016

SCHOOL OF PUBLIC HEALTH
UIC

Strategic Planning Process

May 5

- Planning Process
- Strategic Goals for Priorities

May 23

- Action Plans - Develop strategic alternatives for selected priorities

May 27

- Action Plans - Select optimal alternatives for action directed toward value-added service delivery and the value-added support areas

SCHOOL OF PUBLIC HEALTH
UIC

Strategic Planning Process

May 27 (continued)

- Planning the Implementation – Service Delivery Strategies ("Creation of value that is directly involved in ensuring access to, provision of, and follow-up of health care services.") – Principal Methods for Creating Value
- Planning the Implementation – Support Strategies ("The activities in the value chain that are designed to aid in the efficient and effective delivery of health services.") – Consider the CCHHS's culture, structure, and strategic resources

June 24

- Adopt Proposed Plan

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Strategic Planning Process

Facilitation at All Meetings

- Generate new ideas from stakeholders and Board members
- Question Assumptions - What are we doing now that we should **stop** doing? What are we not doing now, but should **start** doing? What are we doing now that we should **continue** to do but perhaps in a fundamentally different way?

Synthesis

- External Orientation - Acknowledge the reality of change and the impact of the external environment on the CCHHS. Consider the organizational fit with the external environment

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Proposed Priorities

Improve health equity

Provide high quality, safe and reliable care

Demonstrate value, adopt performance benchmarking

Develop human capital

Lead in medical education and medical investigation relevant to vulnerable populations

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